

Office Use Only
Date Received:

Maryland Department of Health
Office for Genetics and People with Special Health Care Needs
Application for Children's Medical Services (CMS) Program

Return to: Children's Medical Services
Maryland Department of Health
201 West Preston Street, Room 423-A, Baltimore, MD 21201-2399

Phone: (410) 767-5588 Toll Free: 1-(800)-638-8864 ***FAXED APPLICATIONS ARE NOT ACCEPTED***

NEW APPLICATION

RENEWAL APPLICATION

1. APPLICANT INFORMATION

Applicant's Last Name _____ First Name _____ MI _____

Social Security Number (if any): _____ - _____ - _____

Date of Birth _____ Sex: Male Female

Address _____

City _____ County _____ State _____ Zip _____

Phone: Primary _____ Secondary: _____ Email Address: _____

Marital Status: Single Married

Ethnicity (check one)	Race (check one)	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> White	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Black	<input type="checkbox"/> Other
<input type="checkbox"/> Unknown	<input type="checkbox"/> Native American	<input type="checkbox"/> Unknown

Is the applicant a citizen of the USA? Please note that US citizenship is not a requirement for eligibility.
 Yes No

What language is spoken in the home? _____

2. MEDICAL INFORMATION

Name of person who referred you to CMS: _____

Address _____ Phone () _____ - _____

_____ Fax# () _____ - _____

Applicant's doctor or pediatrician Name: _____

Address _____ Phone () _____ - _____

_____ Fax# () _____ - _____

List medical problems of applicant:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Describe care or service requested: _____

Are hospital services requested? No Yes if yes, please specify Inpatient Outpatient

When and where the care is needed (location and date of service)?

If requesting pharmacy assistance, indicate pharmacy you would use:

*** Please note Children's Medical Services typically provides pharmacy assistance through Giant Pharmacies.**

Name _____ Phone () _____ - _____

Address _____

3. FAMILY INFORMATION

Last Name	First Name	MI	Address
Mother: _____	_____	_____	_____
Father: _____	_____	_____	_____
Legal Guardian: _____	_____	_____	_____

Please list all family members living in the applicant's household who are **dependents**. A dependent is a person who relies on other people for financial support.

***Put a check before name(s) of family members who already receive CMS services.

Name	Relationship to applicant	Birth date
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

4. FAMILY INCOME AND EXPENSES

Mother: _____
Employer Occupation Work Phone Number

Mother's total **gross earnings** from wages and tips **per week**: \$ _____

(*Gross income means the amount before taxes are taken out)

Did mother become unemployed during the last 12 months? Yes, if yes answer questions below.
 No, if no complete father income information section.

If yes, is she unemployed now? Yes No If yes, when was her last day of work? Date: _____

If she is working now, when did she return to work? Date: _____

Amount of income for 6 months before re-employment: \$ _____

Amount of wages expected for the 6 months following re-employment: \$ _____

Father: _____
Employer Occupation Work Phone Number

Father's total gross earnings from wages and tips **per week**: \$ _____

(Gross income means the amount before taxes are taken out).

Did father become unemployed during the last 12 months? Yes, if yes answer questions below.
 No, if no complete next section of application.

If yes, is he unemployed now? Yes No If yes, when was his last day of work? Date: _____

If he is working now, when did he return to work? Date: _____

Amount of income for 6 months before re-employment: \$ _____

Amount of wages expected for the 6 months following re-employment: \$ _____

Other Income (per month):

Child Support \$ _____

Unemployment Insurance \$ _____
Begin _____ End _____

Workman's Compensation \$ _____
Begin _____ End _____

Disability Benefits including SSI \$ _____

Temporary Cash Assistance (TCA) \$ _____

Insurance Payments received \$ _____

Retirement/Pension Benefits \$ _____

Social Security Benefits \$ _____

Veterans Benefits \$ _____

Trust Fund Income \$ _____

Additional Income:

Includes alimony, income from boarders, income or cash contributions from relatives or other persons, income from property rentals, mortgage income, interest, dividends, royalties, or other income accrued to savings accounts, stocks, bonds, and insurance, and money received from other sources.

Additional Total per month: \$ _____

If you report **no income**, have you applied for public assistance? Yes
 No, if no answer question below.

Please explain how rent/food are provided for the applicant: _____

Expenses you pay out for all members of the family

Loan Payments due to medically related debt
PER MONTH \$ _____

Health Insurance premiums PER MONTH \$ _____

Payments to a hospital or other health care provider you paid yourself in the last 12 months.

	Total Bill	Paid	Balance Due
Doctors	\$ _____	\$ _____	\$ _____
Dentists	\$ _____	\$ _____	\$ _____
Hospital(s)	\$ _____	\$ _____	\$ _____
Prescription Drugs	\$ _____	\$ _____	\$ _____
Eye care/glasses	\$ _____	\$ _____	\$ _____
Special services/equipment (list)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____

5. OTHER BENEFIT INFORMATION

Has application been made to Medical Assistance (MA) or MCHP in the past six months? Yes No

If yes, is the applicant eligible? Yes MA/MCHP Number _____
 No If no, attach a copy of denial letter. Pending

Has application been made for SSI benefits in the past six months? Yes No

If yes, is the applicant eligible for SSI benefits? Yes No Pending

Is the applicant receiving services through any other program?

- Infants and Toddlers Program (birth to 3 years) services
- Special Education/Child Find services
- Mental Health services
- Developmental Disabilities Administration services
- Other (please specify) _____

Is applicant covered by health insurance or a member of an HMO? Yes No

If applicant is covered by health insurance or is a member of an HMO, give name of Plan (s).

1. Insurance Company, Union Local, or HMO _____
Please check: medical/surgical pharmacy dental vision

Name of Policyholder _____

Address _____

Policy Identification number _____

2. Insurance Company, Union Local, or HMO _____
Please check: medical/surgical pharmacy dental vision

Name of Policyholder _____

Address _____

Policy Identification number _____

Person/Agency assisting with completion of application:
Name: _____

Agency/Company: _____

Address: _____

Phone: _____ Fax: _____

**REIMBURSEMENT & COVERAGE AGREEMENT
and
AUTHORIZATION TO RELEASE INFORMATION**

**THE OFFICE FOR GENETICS AND PEOPLE WITH SPECIAL HEALTH CARE NEEDS
FOR CHILDREN'S MEDICAL SERVICES PROGRAM**

I understand that CMS regulations must be followed regarding use of other third party coverage before CMS can pay for any services. I agree to file an insurance claim for any service that insurance may cover. I further agree to refund to CMS any insurance settlements or court-awarded damages which include compensation for health care expenses paid by CMS. Such refund shall not exceed the amount spent by CMS.

I understand that CMS can only pay for services that are provided by those health care providers approved by CMS.

I understand that CMS can only pay for services that have been approved by CMS before the service is provided.

I understand that I have a right to a meeting or informal conference with CMS staff responsible for a decision reflected in any notice of determination issued. I further understand that if, at any time, I disagree with the decision(s) regarding eligibility for services, I may file an appeal requesting a hearing under the provision of Health-General Article § 2-207, and State Government Article Title 10, Subtitle 2, Annotated Code of Maryland.

I understand that my personal medical record is confidential and may be disclosed only in accordance with Federal or State laws. I authorize the release to CMS of all data, records, and information by insurance companies, providers of medical care, financial institutions, federal, state, or local governmental agencies, and any other persons, agencies, or organizations necessary for CMS's pursuit of third party reimbursement or verification of statements provided by me or any other persons whose income and resources will be considered in this application. I understand that this signed application serves as written authorization for any of the above persons, agencies or organizations to release the information required.

I certify that all the information on this application form for Children's Medical Services (CMS) is true, correct, and complete. I understand that any false statement would subject me to penalties under Federal or State law and would result in a denial of program eligibility. I shall inform CMS or the local health department within 10 business days of any changes regarding this application.

Name of Applicant (Please print)

Date of Birth

Signature of Parent(s) / Guardian / Applicant

Today's Date

Signature of Witness

Today's Date